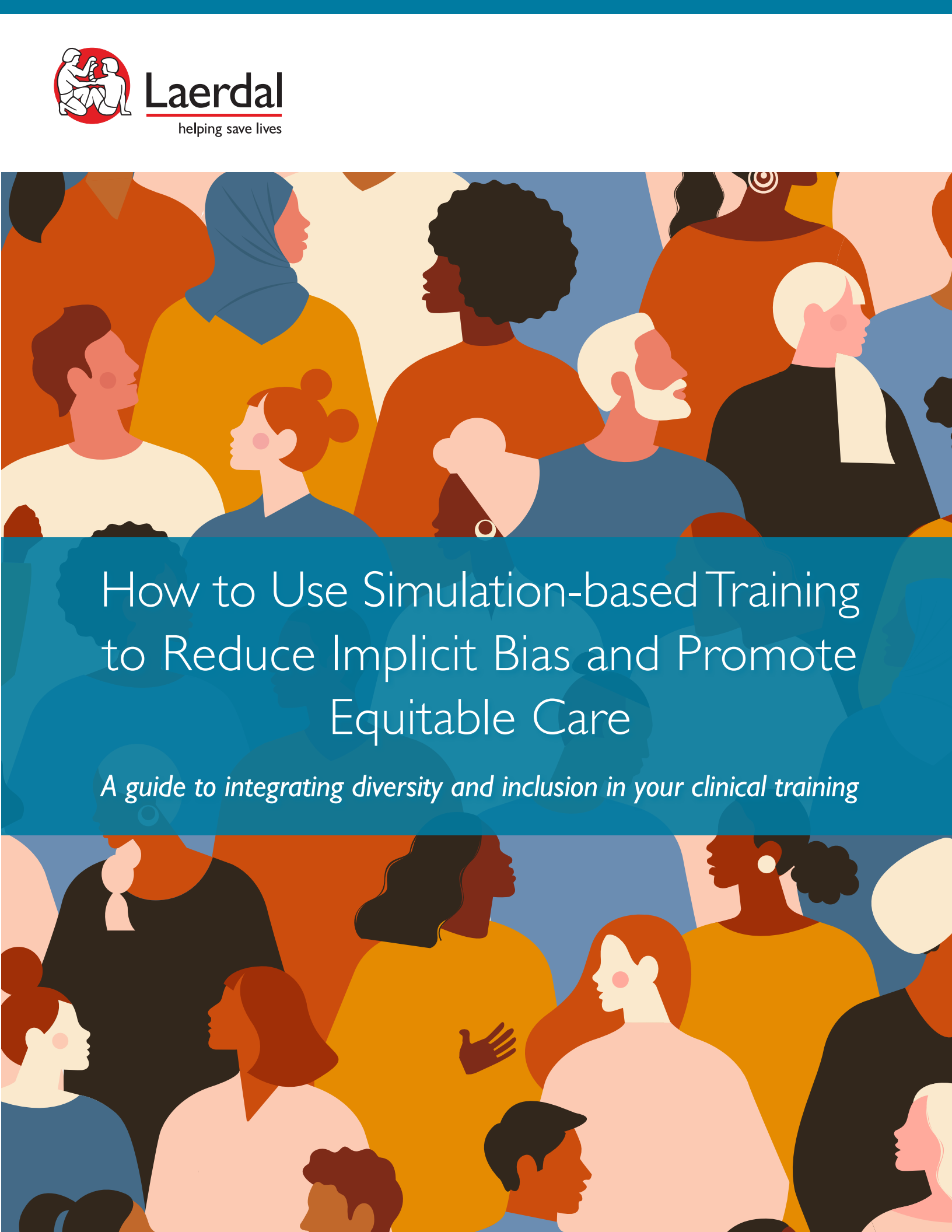




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How to Use Simulation-based Training to Reduce Implicit Bias and Promote Equitable Care

A guide to integrating diversity and inclusion in your clinical training

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*“A person’s culture comes
right to the bedside.”¹*

Martha N. Hill, PhD, RN, FAAN, Professor, Johns Hopkins School of Nursing

Introduction



In 2002, the Institute of Medicine (IOM) published a report entitled “Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare.”² The key conclusion was that people of color receive lower-quality healthcare than Caucasians do, even after adjusting for insurance status, income, age, and severity of conditions.

Over 20 years later, an expanse of research shows that health disparities are still just as prevalent among culturally-diverse patient populations.³

Since the IOM published their report, many healthcare organizations and hospital systems have made attempts to change the trajectory of care for diverse patients. Unfortunately, findings suggest that policy changes, new compliance guidelines, and basic diversity training have not been enough.⁴

The problem is known – disparities exist across dimensions of race, ethnicity, gender, age, education level, disability status, socioeconomic status, and geographic location. The solution, or solutions, can seem far less certain.

There are societal, structural, and personal biases that negatively impact health disparities in the U.S. Where we seek to focus is on the training of healthcare professionals and how stronger training methods can develop more culturally-competent and cognizant providers.

There are many benefits of using simulation to train healthcare providers and providers-in-training, including: making knowledge come alive, increasing clinical understanding, boosting confidence to treat acute cases, and many more. In this eBook, we will discuss how simulation can specifically help to reduce implicit bias and mitigate risk to patients of diverse backgrounds.

On the following pages, you will find current health statistics, example scenario cases, and helpful tools to make or propose an educational shift in your organization. We hope that you take away thoughtful insights to guide more culturally-diverse learning experiences and influence safer, more equitable healthcare.

The Significance of Health Disparities in the U.S. _____

While the term “disparities” is often used to describe differences between racial and ethnic groups, there are many other dimensions of disparity in the U.S.—particularly in healthcare. These dimensions, or health determinants, are complex and intersectional by nature. Therefore, they require careful consideration when preparing healthcare providers for their roles. Some examples are:

- Race
- Ethnicity
- Age
- Gender
- Sexual orientation
- Education
- Culture
- Heritage
- Religion
- Geography
- Physical abilities
- Socioeconomic status

Note: For the purposes of this eBook, the terms “diversity” and “cultural diversity” will encompass these many characteristics.

In comparison with other developed countries, here is how the United States performs:⁵

- The U.S. spends more on healthcare as a share of the economy yet has the lowest life expectancy and highest suicide rate.
- The U.S. has the highest chronic disease burden and 2x the obesity rate average of other developed countries.
- The U.S. has among the highest number of hospitalizations from preventable causes and the highest rate of avoidable deaths.

By focusing on patient-centered care for the most at-risk populations, the nation’s care can be improved overall. This is especially important as we look at underserved populations.



*Analysis estimates that
disparities amount to
approximately **\$93 billion**
in excess medical care costs
and **\$42 billion** in
lost productivity per year
as well as economic losses
due to premature death.⁶*

How COVID-19 Shed New Light on Health Disparities

The COVID-19 pandemic stressed hospital systems and their resources. The impact on patients and their families was devastating. Of those affected, non-white, socioeconomically disadvantaged, and non-English-speaking populations shouldered a disproportionate burden.⁷



Though improving minority health outcomes has been a focus within healthcare for decades, the COVID-19 crisis called attention to long-standing inequities that affect care in hospitals across America. Today, there is growing public awareness and a sense of urgency.

Recent research studies found that:

Black patients were 5.4x more likely than those of other races to test positive with COVID-19.⁸

Low-income, minority children were 2.3x more likely than White children to have a coronavirus infection.⁹

Non-English speakers tested positive for COVID-19 at 4.6x the rate of English speakers.¹⁰

“Clinicians, health systems, and policy makers alike must grapple with the fundamental inequities that lie upstream of disparate COVID-19 outcomes to make tangible process toward health justice.”¹¹

Reap Positive Results with Simulation-based Training

Looking at the overarching factors that affect a patient's care, simulation cannot solve all concerns. However, **it can help to change behavior faster and better than other methods used to train healthcare providers.**



Compared with didactic teaching methods, such as lectures, discrimination training, and policy updates, simulation is best known as the method that makes learning “stick”. Hospitals and nursing schools that have adopted simulation training have seen the following improvements:^{12, 13, 14}

- Higher engagement
- Improved clinical retention
- Teamwork and communications
- Positive patient outcomes
- Reduced turnover
- Increased provider confidence
- Coordinated responses to low-frequency, high-acuity cases
- Better Compliance



It is important to note that diversity training through simulation requires far more than a simulator or manikin with a different skin tone or gender. In order to achieve learning outcomes directly related to diversity, you will need to modify steps in your planning, facilitating, and debriefing.

Types of Simulation

Types of Simulation:

Standardized Patient – A person who has been carefully coached to simulate an actual patient, presenting the history, body language, physical symptoms, as well as the emotional and personality characteristics.

Task Trainer – A device designed to train in just the key elements of the procedure or skill being learned, such as lumbar puncture, chest tube insertion, central line insertion, etc.

Manikin – A full or partial body representation of a patient for practice. Typically, manikins are used for a more refined set of skills training.

Low-Fidelity Simulation – Simulation techniques and solutions that do not require external programming for the learner to participate. Examples include case studies, role playing, and task trainers used in a clinical practice situation.

High-fidelity Simulation – Refers to simulation experiences that are highly realistic and provide a high level of interactivity and realism for the learner.

Hybrid Simulation – The union of two or more modalities of simulation. Most commonly, this applies to a situation where a task trainer is realistically affixed to a standardized patient allowing for the teaching and assessment of technical and communication skills in an integrated fashion.

Virtual Simulation – A person operates simulated systems to mimic a patient case virtually.

Virtual Reality (VR) Simulation – Virtual simulations that utilize VR headsets to immerse learners in an array of environments. Students can often “pick up” items in their environment and talk to patients the same way they would in real life.

Mixed Reality (MR) Simulation – Simulations that combine both virtual and physical elements. Simulation that utilizes the hybrid combination of virtual reality environments and reality, such as a manikin.

Whatever your level of simulation expertise, pretend for a moment that you are a novice. Look beyond the features of available technology and return to your learning objectives. Ultimately, these will dictate the best type of clinical simulation solution to meet your needs.

Ask yourself:

- What are relevant and timely patient cases that require a keen sense of cultural awareness for your institution? Are there any recent patient stories circulating in the news? Has there been a recent sentinel event in your organization or your region?
- What type of knowledge and awareness do I want my learners to leave the session with? Do you want to challenge their critical thinking skills according to a specific cultural characteristic? Do you want them to become aware of a particular religious boundary? Do you want them to become aware of a pre-conceived notion about a specific group?
- What type of experience will create an awareness of carried biases and encourage cultural humility in learners? How can I bring this experience to life using simulation as a modality? What type of simulation will enhance and not distract from this experience?

Introduce Cultural Diversity Through Realistic Sim _____

How Can You Create an Authentic and Diverse Simulation Experience?

First and foremost, you will have to switch the lens that both facilitators and learners are looking through. Rather than centering your simulation around specific clinical tasks or specific teamwork strategies, you want to turn all attention to the patient. **Just the patient and any of the cultural characteristics that might impact their health.**

This seems intuitive in healthcare. After all, the patient is the primary concern. But how often are cultural characteristics either overlooked or ignored with well-meaning intentions to treat all patients the same?

The goal of simulating for diverse patient populations is to distinguish one individual patient from the next. These differences are the key to providing safe and equitable care.

Our Advice: Focus on Priority Populations for Public Health in Your Area

Orient your simulation scenario around a patient group that is faced with negative health outcomes. Focus on areas where there is the most room for improvement.

On the following pages, we categorize research on select at-risk populations and offer some suggestions to planning a simulated patient case.

Social Determinants of Health

While some health disparities may be caused by biological differences, many disparities are caused by external conditions. These social determinants can shape health outcomes such as mortality rates, alcohol and substance abuse, mental health disorders, and violence victimization – all of which play into the patient encounter.¹⁶

<i>Economic Stability</i>	<i>Neighborhood and Physical Environment</i>	<i>Education</i>	<i>Food</i>	<i>Community and Social Context</i>	<i>Health Care System</i>
Employment Income Expenses Debt Medical Bills Support	Housing Transportation Safety Parks Playgrounds Walkability Zip Code/ Geography	Literacy Language Early Childhood Education Vocational Training Higher Education	Hunger Access to Healthy Options	Social Integrtrion Support Systems Community Engagement Discrimination Stress	Health Coverage Provider Availability Provide Linguistic and Cultural Competency Quality of Care
<i>Health Outcomes¹⁷</i> Mortality, Morbitiy, Life Expectancy, Health Care Expenidtures, Health Status, Functional Limitation					

While your simulated patient case won't cover all the information in this chart, you may want to provide it to facilitators and learners. It can serve as a starting point for your discussions.

Racial & Ethnic Disparities

By 2050, it is estimated that 50% of the U.S. population will consist of racial and ethnic minorities.¹⁸ As many cities throughout the U.S. have already become minority-majority, the imperative to address ethnic and racial health disparities grows.

Some stats to share with your learners:

American Indian
and Alaska Native
infants die from SIDS
at nearly 2x the rate
of white infants.¹⁹

Native Hawaiian
and other Pacific
Islanders are 76%
more likely to be
obese.²⁰

Hispanics are 2.5x
more likely to be
uninsured than
Whites.²¹

Black mothers
are 3x more likely
to die from a
pregnancy-related
complication.²²

African American
patients are
2x as likely to
have a stroke.²³

For more statistics like these,
check out our [Minority Health
Statistics infographic](#).

Simulation can help providers recognize cross-cultural issues in interviewing, communicating medical information, and providing treatment for patients from varying ethnic and racial backgrounds.²⁴

Your goal may be to teach learners to look for physiological symptoms that are unique to different skin tones. Or it may be to bring awareness to an ailment that typically targets a specific ethnic group.

To a certain degree, simulation asks that learners dispense disbelief. However, by using a simulator that represents a real person you can bring the scenario to life.



[NextGen vSim® for Nursing](#)



[MamaAnne](#)

Scenario Example:

Multiple studies have shown that pain is often undertreated in Black expectant and new mothers.²⁵ Explore that phenomenon through a simulated experience: A 34-year old Black woman returns to the hospital 3-weeks postpartum after a high-risk pregnancy battling a clotting disorder and high blood pressure. She had a C-section birth and is suffering a painful hematoma at her incision and has also been suffering headaches, blurred vision, and leg edema.

Breaking Down Language Barriers

Inadequate provider-patient communication is often a contributing factor to patient noncompliance, poor patient outcomes, and litigation.²⁶ In multicultural populations, the issue of miscommunication can become detrimental to a patient's health and it is critical for providers to avoid making assumptions based on race or ethnicity. Simulation can introduce learners to the practice of asking for a person's background, how they choose to be identified, and what their preferred language is.

Simulation also affords an opportunity for learners to get comfortable navigating and removing language and cultural barriers. For example, here are some steps toward reducing risk to a patient that can be incorporated into your scenarios.²⁷

Encourage your learners to use the L.E.A.R.N. acronym:

- **L**isten to the patient's perception of the problem.
- **E**xplain your perception of the problem.
- **A**cknowledge and discuss differences and similarities.
- **R**ecommend treatment.
- **N**egotiate treatment.

Include the role of an interpreter.

Train learners to use closed-loop communication when speaking with the interpreter and patient. This means repeating what was said and ensuring that the patient ultimately understands what is being discussed.



Nursing Anne Simulator African Descent



The *Nursing Anne Simulator* platform offers a variety of age, race and patient conditions to create a unique learning experience.

Scenario Example:

Use the voice-control feature on a high-fidelity simulator to allow for interpersonal as well as clinical practice. The case: a young Dominican woman with limited English-speaking skills presents with hypertension. Despite visits with multiple physicians, her blood pressure is still poorly controlled. Guide learners to uncover that she did not understand the complex medication regimen she had been given.

Gender Disparities

The Knowledge Gap & the Trust Gap

In the 1990's, women's advocates drew attention to the fact that women were largely being left out of clinical research.²⁸ Although studies since then have included more women, there is still considered to be a "knowledge gap" surrounding women's health.

Diseases that disproportionately affect women (like autoimmune diseases, fibromyalgia, and chronic pain conditions) have largely been under-researched. This, in addition to anecdotes about providers dismissing female patient concerns, has resulted in a "trust gap" that affects women's perception of healthcare services.²⁹



Scenario Example:

Heart disease is the leading cause of death for women in the U.S.³⁰ While male symptoms are more well-known, women can sometimes exhibit no symptoms at all. Simulate a middle-aged White woman reporting pain in the jaw and throat as well as nausea. See what your students come up with.

[Nursing Anne Simulator](#)

Similarly, while most studies on gender disparities focus primarily on males and females, it is important to include transgender and intersex patients in your educational curriculum too.

Transgender people face an increased risk of HIV infection (particularly among transgender women of color) and a lower likelihood of preventative cancer screenings among transgender men.³¹

Scenario Example:

A 28-year old transgender male who has not had sex reassignment surgery requires a vaginal exam and pap smear by an OB-GYN. Use a standardized patient to practice the history-taking and record the encounter to review the learner's language, body language, and line of questioning.

A simulated learning experience focused on any type of gender disparities will require realistic genitalia and anatomical landmarks, as well as strong rapport-building skills. Not feeling comfortable asking certain questions (such as sexual orientation, a patient's preferred pronouns, or whether they are taking hormones) can create a barrier to quality care, and simulation practice can help to remove that barrier.

Age Disparities

As Americans live longer, growth in older adult populations is unprecedented. In 2014, 14.5% of the U.S. population was aged 65 or older.³² This number is projected to reach 23.5% by 2060.³³

In addition to increasing in the sheer number of people, aging adults also experience a higher risk of chronic disease.³⁴ Experts have raised concerns that healthcare systems will need to prepare for increased incidences of chronic conditions as well as implement multidisciplinary approaches to managing a patient's case.³⁵ And, as the demand for home health and personal care aides also grows, there is yet another segment to incorporate in the elderly continuum of care.³⁶

This is precisely where simulation can make the difference. One study measured the impact of simulation training on skills required to address delirium, falls, elder abuse, and breaking bad news to patients and their families.³⁷ Using a combination of standardized patients, simulators, and simulated clinical documentation, learners significantly improved in:

- Knowledge.
- Skills retention.
- Positive perceptions of geriatric medicine.



Scenario Example:

Falls are the leading cause of injury among older adults. Every year, 1 out of 3 older adults fall, yet less than half tell their doctor.³⁸ Simulate an assessment of an elderly woman brought in by her grandson after a fall, being sure to highlight tests to identify possible underlying conditions.

[Nursing Anne Simulator Geriatric](#)

Socioeconomic Disparities

The U.S. has one of the largest income-based health disparities in the world.³⁹ And, individuals with incomes below poverty are 4x as likely to lack coverage as those with incomes at 400% above the federal poverty level.⁴⁰

When considering that socioeconomic status (SES) underlies three major determinants of health outcomes – healthcare, environmental exposure, and health behaviors – it becomes a top priority to address implicit bias toward patients of a lower SES in your training.

Research demonstrates more attention given to pain control in patients with higher socioeconomic statuses as well as a trend toward better communication.⁴¹

One study showed clinical decision making and discharge planning were often tailored to a patient's SES.⁴²

Simulation-based training can help to bring an awareness to the subtle behaviors that are associated with patient bias, such as maintaining distance or avoiding eye contact. It can also shed light on some larger issues, such as the tendency to share more medical information with higher-SES patients, therefore involving them more in their own decision-making.⁴³



SimMan® 3G PLUS

Scenario Example:

Often, SES is interpreted through appearances alone. One way to shine a light on the learners' implicit biases is to run the same simulation two times – once with a low-SES homeless man and once with a high-SES businessman.

Teaching Cultural Competency, One Step at a Time

Each of the priority populations discussed intersect in one way or another. It is important to keep this in mind and to keep learners from categorizing patients in silos. Here are some findings that may help bring the overlapping, intertwining nature of patient characteristics to the front of your learners' minds:

- Spanish-speaking Latinos are less likely than Whites to visit a physician or mental health provider, or receive preventative care, such as a mammography exam or influenza vaccine.⁴⁴
- Over 25 million Americans aged 60+ are economically insecure—living at or below 250% of the federal poverty level.⁴⁵
- Elderly patients as well as racial and ethnic minorities are more likely to have lower levels of literacy. This affects patients' ability to read and understand instructions on prescription medicine bottles, health education materials, and insurance forms.⁴⁶

Cultural competence in healthcare refers to the ability of providers and organizations to understand and integrate these factors into the delivery and structure of the health care system.⁴⁷

Start with one priority population and gradually begin to include all aspects of underserved patient populations in healthcare. The more exposure, awareness, and practice learners have with these concepts, the stronger care providers they will be.

Create an Open-minded Learning Environment

For healthcare providers to address unconscious biases, **they must learn to recognize intrinsic blind spots**. Many of these blind spots are the result of confirmation bias, which means reinforcing prior beliefs while disregarding new information that doesn't reinforce those beliefs.

In order to teach the constant vigilance and self-awareness required to provide unbiased care, it can help to set expectations and ground rules before you begin your simulation.

Below, we provide a mock-up of what your guidelines might look like.

Open-mindedness Guidelines in the Simulation Lab:

- ✓ I am a willing participant of this simulation and, as such, I will be fully present, engaged, and open to new learning.
- ✓ I agree to contribute positively to the learning environment and maintain an open-mind to observations, feedback, and questions.
- ✓ I understand that my beliefs, values, and culture may not be the same as someone else's.
- ✓ I understand that this is an opportunity to try different ways of providing care, but that does not necessarily mean previous ways of treating patients have been "wrong."
- ✓ I understand that some aspects within this learning experience may cause me to question the world around me.
- ✓ At the conclusion of the simulation, I will take part in a thoughtful reflection of this experience.

DO's

- Practice what you preach
 - Be open to new ideas.
 - Show respect for differing opinions.
 - Note and override micro-aggressive comments.
- Be receptive to challenging questions.
- Start with shorter, simplified scenario cases to avoid overwhelming participants.
- Address learners where they are in the moment, not where you expect them to be at the end of the lesson.
- Understand that it is natural for people to feel frustrated when they discover their own implicit bias. Be patient!
- Foster a “cultural desire” among learners so that they **want** to engage in the process of becoming more culturally-aware.

DON'Ts

- **Never wing it.** Designing and facilitating diverse simulation scenarios require precise planning and practice for a successful execution.
- **Avoid stereotypes.** Be careful not to reinforce common stereotypes in your simulation cases. For example, do not make the homeless patient a drug-user.
- **Don't use jargon that only experts understand.** Meet your learners where they are by using a layperson's vocabulary.
- **Do not generalize.** Consult someone who understands the cultural elements you are incorporating in your sim. For example, if you do not know the difference between a hijab, a niqab, and a burka, ask for help!
- **Do not target or publicly embarrass a participant.** Part of creating a safe learning environment means not making learners feel bad about their mistakes. We all make them.

Train Learners to Hold Each Other Accountable

TeamSTEPPS is an evidence-based program aimed at optimizing performance among healthcare teams, enabling them to respond quickly and effectively to whatever situations arise.⁴⁹

If you've ever used an SBAR (Situation, Background, Assessment, Recommendation) to report on a patient case, you've used a TeamSTEPPS tool! There are many more, and they are all designed to expedite patient care and take risk out of the care equation.

These same tools can be used to monitor one's own cultural awareness and to call out another provider's potential bias in a professional manner.

Communication

✓ **SBAR**

Facilitates prompt and appropriate communication (Acronym for Situation, Background, Assessment, Recommendation)

✓ **Call-Out**

Used to communicate important or critical information to all team members simultaneously during emergent situations.

✓ **Check-Back**

Using closed-loop communication to ensure information conveyed by the sender is understood by the receiver as intended.

✓ **Handoff**

The transfer of information, authority, and responsibility during transitions in care. It should always include an opportunity to ask questions, clarify, and confirm details. Some may use "I PASS THE BATON" acronym.

Leading Teams

✓ **Brief**

Short session prior to start. Includes: sharing the plan; discussing team formation; establishing expectations and climate; anticipating outcomes.

✓ **Huddle**

Ad hoc meeting to re-establish situational awareness.

✓ **Debrief**

Informal information exchange to share lessons learned and reinforce positive behaviors.

Situation Monitoring

✓ **STEP**

Used to assess the healthcare situation (Acronym for Status of the patient, Team members, Environment, Progress toward goal)

✓ **I'M SAFE**

Used by individual team members to assess his or her own safety status (Acronym for Illness, Medication, Stress, Alcohol and drugs, Fatigue, Eating and elimination)

Mutual Support

✓ **Task Assistance**

Team members foster a climate where it is expected that assistance will be actively sought and offered.

✓ **Feedback**

Information provided to team members for the purpose of improving team performance. It should be timely, respectful, specific, directed toward improvement, and considerate.

✓ **Assertive Statement**

Assert a corrective action in a firm and respectful manner.

✓ **Two-Challenge Rule**

It is each team member's responsibility to assertively voice a safety concern at least two times to ensure it has been heard.

✓ **CUS**

"I am concerned", "I am uncomfortable", "This is a safety issue"

✓ **DESC Script**

A constructive approach for managing and resolving conflict. (Acronym for Describe the specific situation, Express how the situation makes you feel, Suggest alternatives, Consequences should be stated in terms of impact on established team goals)

Debriefing for Cultural Humility

Those who teach using simulation often argue that the debriefing session following the simulation is where most of the learning occurs. **It is only through the debrief that learners can fully absorb the information, discuss what they've learned, and then change their behavior in future situations.**

Cynthia Foronda, PhD, RN, CNE, CHSE, ANEF, researched and developed the Theory of Cultural Humility, which presents the framework to address the multiple influences in a diverse scenario.

Cultural humility is defined as the recognition of diversity and power imbalances among individuals, groups, or communities, with the actions of being open, self-aware, ego-less, flexible, exuding respect and supportive interactions, focusing on both self and other to formulate a tailored response. *Using this framework to navigate the simulation debrief can help learners critically reflect on past events with the lens of better recognizing and understanding diversity as well as cultural humility.*⁴⁹

Debriefing for Cultural Humility[©]

I. Diversity, Context, and Power Imbalances (Antecedents)

1. How did that feel? (Start by assessing emotion.)
2. What types of diversity were present between provider and patient?
3. Are there any historical precedents or political situations that might be at play?
4. Were you aware of any individual diversity characteristics with respect to personal beliefs and values that were apparent?
5. What was the situational context of the conflict?
6. Did you notice anything in the physical environment that seemed relevant to the conflict?
7. What power imbalances did you perceive?
8. In what ways is the patient/family/community in the minority?
9. In what ways is the health care provider in the minority?
10. What thoughts go through your mind when you are faced with a conflict? Do you want to be curious and learn more or avoid it? Is conflict a normal part of life?

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Debriefing for Cultural Humility (Continued)

2. Cultural Humility (Attributes)

1. In what ways did the health care provider focus on the patient? Was care patient-centered?
 2. In what ways did the health care provider focus on his/herself? Who received more focus?
 3. Did the health care provider demonstrate flexibility or rigidity? If so, in what ways?
 4. Did the patient demonstrate flexibility or rigidity? If so, how?
 5. How might the healthcare provider's actions impact patient-centered care?
 6. What are some strategies you saw or might consider using to level the power imbalances or flatten the hierarchies in this event?
 7. What actions might have demonstrated cultural humility?
 8. Did the health care provider demonstrate openness to listening to the patient? What are ways to convey being open?
 9. How were the interactions/communications between healthcare provider and patient?
 10. How did the health care team function? How was the communication within the team?
-

3. Outcomes (Consequences)

1. In what ways was the patient empowered?
2. How were the patient's thoughts, beliefs, and values integrated into the plan of care? Did the patient receive optimal care? Why or why not?
3. Did the healthcare provider develop a partnership with the patient? Why or why not?
4. Did you sense a feeling of respect? What are ways of fostering respect in this situation?
5. What were the positive outcomes for the patient? What were the positive outcomes for the provider? For the care team? For the institution? For the community?
6. Were there any negative outcomes that you perceived or anticipate?
7. What are some of the potential implications of the health care provider's decisions and actions?
8. Cultural humility is a process of self-awareness and life-long learning. How might you apply what you learned today about diversity and cultural humility in the future? (End by reinforcing lifelong learning.)

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Debriefing Tips for Success

The reflective process of debriefing is a cornerstone of Kolb's experiential learning theory.⁵⁰ By following a concrete experience (the simulation) with observation and reflection (the debrief), learners can form ideas about their performance and determine what they need to do differently next time.

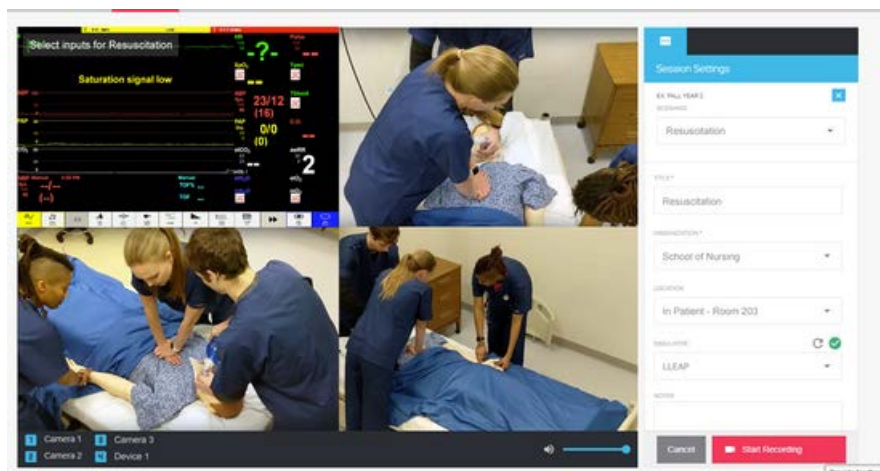
Some essential elements of effective debriefing include:

- ✓ Ensuring a supportive climate among peers.
- ✓ An established set of rules for engaging as a group.
- ✓ A shared mental model with input from the facilitator.
- ✓ Individuals being granted the space to process their reactions and feelings related to the scenario.
- ✓ More time dedicated to the debrief than the simulation experience itself.
- ✓ Participants doing most of the talking.

Use Video Technology to Create Deeper Connections to the Material

Debriefing a simulation scenario encourages better understanding of the learning concepts, but it's worth considering how to take this one step further with video recording.

The line of debriefing questions will uncover a retrospective look at the learners' performance. Giving these same learners an opportunity to review a video playback of themselves and their peers can lead to a more thorough analysis of the situation. This includes spotting and calling out stereotypes, biases, and inequities that might otherwise go unnoticed.

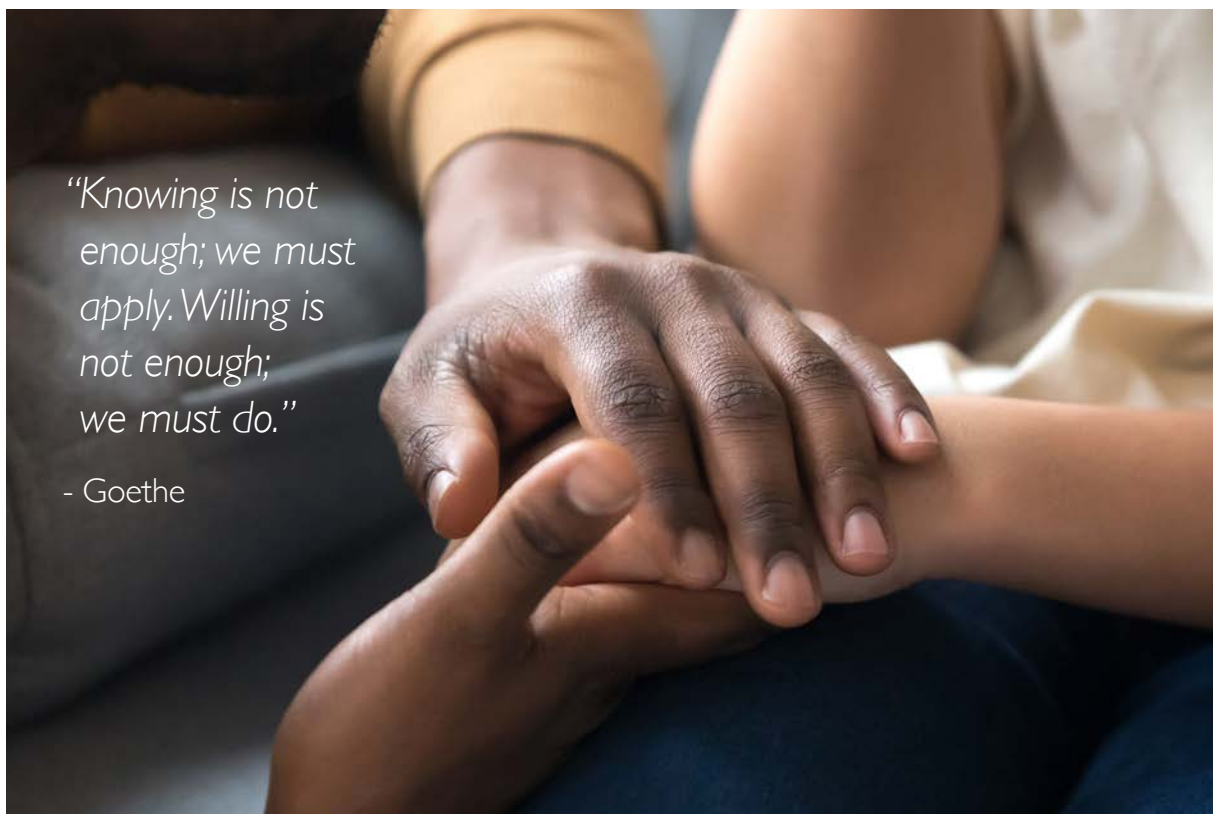


SimCapture can help you to manage, assess, and debrief your simulations. It can also provide reports and statistics on performance, as well as capture student evaluations.

A Final Word

In healthcare, there is a known underrepresentation of cultural, gender, and ethnic diversity during training and in leadership.

To truly serve the needs of a diverse population, it is critical to implement training that will promote cultural competence, cultural humility and a strong sense of clinical empathy.



Simulation is a strong means to develop the necessary skill set to provide high-quality care for all patients. However, as we wrap-up this eBook, we'd like to leave you with one final thought: **Implicit bias, which can stand in the way of safe patient care, cannot be eliminated overnight. Nor can it be reduced by one singular training session.**

Reducing bias and providing equitable care requires a life-long commitment and unwavering vigilance.

At Laerdal, we are committed to providing you with solutions and support to help save more lives – across the entire spectrum of patients, ensuring equitable healthcare for all.

Additional Resources

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To learn more about simulation solutions to train for diverse patients, visit:
[Laerdal.com/DiversityResources](https://laerdal.com/DiversityResources)

To stay up to date on Laerdal's published content, subscribe to our email list [here](#).

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